Clinical Policy: FEHB Fertility Preservation

Reference Number: QCP.CP.042
Last Review Date: 04/26

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy is specific to the Federal Employees Health Benefits.

Fertility may be transiently or permanently affected by medical treatments such as bilateral oophorectomy, gonadotoxic therapy, cytotoxic chemotherapy, or radiation therapy, as well as by other iatrogenic causes. Rates of permanent infertility and compromised fertility after medical treatment vary and depend on many factors, including the drug, size, and location of the radiation field if applicable, dose, dose-intensity, method of administration (oral versus intravenous), disease, age, treatment type and dosages, and pretreatment fertility.

***Note**: For criteria related to cryopreservation, please see QC.MP.027 FEHB Infertility Coverage.*

Storage is limited to one (1) year and benefits are limited to one cycle of fertility preservation per covered person during the entire period the member is enrolled with QualChoice.

Policy/Criteria

I. It is the policy of QualChoice that, when a covered benefit under the member's/enrollee's benefit plan contract, any of the following procedures are **medically necessary** for members/enrollees with a female reproductive system prior to commencing medically necessary treatment that is likely to cause infertility (excluding voluntary sterilization):

A. Ovarian stimulation and retrieval of oocytes;
B. Ovarian tissue retrieval and all of the following:
   1. Ovarian tissue with no evidence of malignancy;
   2. Insufficient time for oocyte retrieval or member/enrollee is prepubertal;
C. Ovarian transposition (oophoropexy).
D. Radiation (gonadal) shielding;
E. Infertility associated with medical and surgical gender transition treatment.
F. Conservative gynecologic surgery including but not limited to the following:
   1. Radical trachelectomy in early stage cervical cancer (i.e., stage IA2 to IB cervical cancer with diameter <2 cm and invasion <10 mm);
   2. Ovarian cystectomy for early-stage ovarian cancer.

***Note**: For those with female reproductive systems ≥ age 40 requesting retrieval of their own oocytes, documentation is required noting that the treating provider has evaluated age, infertility risk factors, measure of ovarian reserve, and considers use of the member/enrollee's own oocytes a viable strategy for attempting future conception.*

II. It is the policy of health plans affiliated with Centene Corporation that there is insufficient evidence in the published peer-reviewed literature to support the use of the following procedures for fertility preservation in members/enrollees with a female reproductive system prior to commencing treatment that is likely to affect fertility:
   A. Ovarian suppression with gonadotropin releasing hormone (GnRH) agonist or antagonists.
   B. Cryopreservation of immature oocytes;
   C. Ovarian tissue cryopreservation and transplantation procedures;

III. It is the policy of QualChoice that, when a covered benefit under the member's/enrollee's benefit plan contract, the following procedures are **medically necessary** for members/enrolleess with a male reproductive system prior to commencing medically necessary treatment that is likely to cause infertility (excluding voluntary sterilization):
   A. Sperm extraction and retrieval procedures.
   B. Cryopreservation of sperm;
   C. Radiation (gonada) shielding.
   D. Infertility associated with medical and surgical gender transition treatment.

IV. It is the policy of health plans affiliated with Centene Corporation that there is insufficient evidence in the published peer-reviewed literature to support the use of the following procedures for fertility preservation in members/enrollees with a male reproductive system prior to commencing treatment that is likely to affect fertility:
   A. Testicular suppression with GnRH agonist or antagonists;
   B. Reimplantation or grafting of human testicular tissue.
   C. Testicular tissue or spermatogonial cryopreservation

Background

An estimated 4.4% of all new cancer cases occur among adolescents and young adults between the ages of 15 to 39. Cancer patients are surviving at increasing rates, but successful treatment in younger patients can often be gonadotoxic and lead to late and long-term effects such as infertility. Treatment can affect fertility by causing damage to immature eggs and reproductive organs and affecting the body's hormones. Fertility preservation is an essential part of the management of adolescents and young adults who are at risk for infertility due to cancer treatments.[11]

Gonadotoxic treatments include chemotherapy, radiation, and surgical resection (for treatment of disease or gender affirmation surgery). Additionally, chemotherapy can be used for noncancerous conditions such as autoimmune diseases, like systemic lupus erythematosus, and hematological disease. Prompt counseling regarding available options for fertility preservation for iatrogenic infertility should be provided to patients prior to undergoing any gonadotoxic treatments.[10]

American Society for Reproductive Medicine (ASRM)[10*]
The 2019 ASRM committee opinion for Fertility Preservation in Patients Undergoing Gonadotoxic Therapy or Gonadectomy affirmed that ovarian tissue cryopreservation is no longer considered experimental for prepubertal girls and for those who cannot delay cancer treatment to undergo ovarian stimulation and oocyte retrieval. According to the committee, "data on the efficacy, safety, and reproductive outcomes after ovarian tissue cryopreservation are still limited. Given the current body of literature, ovarian tissue cryopreservation should be considered an established medical procedure with limited effectiveness that should be offered to carefully selected patients."

However, the guideline states that the use of gonadotropin-releasing hormone (GnRH) analogs for ovarian protection during chemotherapy remains controversial. Furthermore, GnRH analog therapy for fertility preservation in males has failed to demonstrate effectiveness.

American Society of Clinical Oncology (ASCO)[5*]
The ASCO recommends discussing fertility preservation with all patients of reproductive age (and with parents or guardians of children and adolescents) if infertility is a potential risk of therapy, as early as possible, before treatment starts.

For individuals with a male reproductive system who express an interest in fertility preservation, sperm cryopreservation is the only established fertility preservation method. ASCO notes that in these patients, hormonal therapy has not shown to be successful in preserving fertility. Per ASCO, other methods, including testicular tissue cryopreservation for the purpose of future reimplantation or grafting of human testicular tissue, are experimental.

For individuals with a female reproductive system who express an interest in fertility preservation, both embryo and oocyte cryopreservation are established fertility preservation methods. The ASCO notes that evidence for ovarian tissue cryopreservation for the purpose of future transplantation remains insufficient; however, the field of ovarian tissue cryopreservation is advancing quickly and may evolve to become standard therapy in the future though it should also be noted that further investigation is needed to confirm whether it is safe in patients with leukemias. They note, also, there is insufficient evidence regarding the effectiveness of ovarian suppression with GnRH agonist or antagonists to preserve fertility.

In the 2025 update, new recommendations include offering fertility counseling at the time of diagnosis and including fertility preservation after cancer treatment. Additionally, ASCO now notes that in vitro maturation (IVM) of oocytes may be offered as an emerging method of fertility preservation of some patients prior to cancer treatment.

National Comprehensive Cancer Network (NCCN)[8*]
NCCN guidelines on Adolescent and Young Adult Oncology note that oocyte or embryo cryopreservation is recommended for those that can delay cancer therapy for approximately three weeks. Ovarian tissue cryopreservation is a promising strategy for fertility preservation when there is insufficient time for oocyte or embryo cryopreservation and/or the patient is prepubertal. Hormonal stimulation is not required with this technique; therefore, there is no delay in the initiation of treatment. However, this procedure is not appropriate for certain patients, including

carriers of BRCA mutations due to the increased risk of ovarian cancer and those with cancer if potential exists for reintroduction of malignant cells with grafting. While ovarian tissue cryopreservation is still considered investigational at some institutions, it may be discussed as an option for fertility preservation.

Some data suggests menstrual suppression with GnRH agonists may protect ovarian function. However, evidence that menstrual suppression with GnRH agonists provides adequate protection of the ovaries is controversial, so this procedure is not currently considered a form of fertility preservation.

American College of Obstetricians and Gynecologists (ACOG)[6*]

ACOG's Gynecologic Issues in Children and Adolescent Cancer Patients and Survivors committee opinion states that "cryopreservation of oocytes or embryos may be offered before cancer treatments if there is adequate time and a safe method for ovarian stimulation. Ovarian tissue extraction and cryopreservation have been shown to have some success with posttreatment auto transplantation after chemotherapy."

For young individuals with a female reproductive system who have completed sexual development, GnRH agonists and antagonists, such as leuprolide acetate, have been used to induce ovarian quiescence to preserve ovarian function and fertility after cytotoxic treatment. Leuprolide acetate is not recommended prior to puberty. There still is no conclusive evidence that demonstrates efficacy of GnRH agonists and antagonists, and studies are primarily observational regarding their effectiveness in fertility preservation.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
00922	Anesthesia for procedures on male genitalia (including open urethral procedures); seminal vesicles
55870	Electroejaculation
55899	Unlisted procedure, male genital system
58970	Follicle Puncture for oocyte retrieval, any method
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete

CPT® Codes	Description
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation
77334	Treatment devices, design and construction, complex (irregular blocks, special shields, compensators, wedges, molds or casts)
89254	Oocyte identification from follicular fluid
89259	Cryopreservation; sperm
89268	Insemination of oocytes
89272	Extended culture of oocytes/embryo(s), 4-7 days
89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes
89281	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes
89320	Semen analysis; volume, count motility and differential
89337	Cryopreservation, mature oocyte(s)
89352	Thawing of cryopreserved; embryo(s)
89353	Thawing of cryopreserved; sperm/semen, each aliquot
89398*	Unlisted reproductive medicine laboratory procedure
99000	Handling and/or conveyance of specimen for transfer from office to a laboratory
99001	Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services in a group setting (eg, prenatal, obesity, or diabetic instructions)
99199	Unlisted special service, procedure or report

HCPCS Codes	Description
S4030	Sperm procurement and cryopreservation services; initial visit
S4031	Sperm procurement and cryopreservation services; subsequent visit

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
C00.0-D49	Neoplasms
D27.0	Benign neoplasm of right ovary
D27.1	Benign neoplasm of left ovary
D39.10-D39.12	Neoplasm of uncertain behavior of ovary

ICD-10-CM Code	Description
D40.10-D40.02	Neoplasm of uncertain behavior of testis
N70.01-N70.03	Acute salpingitis and oophorits
N70.11-N70.13	Chronic salpingitis and oophoritis
N83.511-N83.519	Torsion of ovary and ovarian pedicle
Z31.84	Encounter for fertility preservation procedure

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review	10/07/2025	10/2025
Ad-hoc Review, updated with criteria from Centene cp.mp.130, updated background information, reviewed code lists	04/17/2026	04/2026

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Application to Products

This policy applies to all health plans and products administered by QualChoice, both those insured by QualChoice and those that are self-funded by the sponsoring employer, unless there is indication in this policy otherwise or a stated exclusion in your medical plan booklet. Consult the individual plan sponsor Summary Plan Description (SPD) for self-insured plans or the specific Evidence of Coverage (EOC) or Certificate of Coverage (COC) for those plans or products insured by QualChoice. In the event of a discrepancy between this policy and a self-insured customer's SPD or the specific QualChoice EOC or COC, the SPD, EOC, or COC, as applicable, will prevail. State and federal mandates will be followed as they apply.

QualChoice reserves the right to alter, amend, change or supplement medical policies as needed. QualChoice reviews and authorizes services and substances. CPT and HCPCS codes are list

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria

set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.